Bradley D. Powell, PhD

Psychological Consultants of the Brazos Valley, P.A.

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read both sides of this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient's Full Name: _____

Street Address:_____

City, State, and Zip:_____

Phone Number:_____

Date of Birth:_____

Medical Record Number/Social Security Number____ _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

From: Person/Organization:_____

Address:_____

City State Zip:_____

To: Person/Organization:_____

Address:_____

City, State, Zip:_____

Purpose or Need for Information:_____

Disclosure will include (check all that apply):

_____Face Sheet _____History & Physical _____Laboratory Report

_____Psychological Report _____Discharge Summary _____Progress/Physician Notes

_____Treatment Summary _____Pathology Report _____Emergency Report

_____Therapy Notes _____EKG/EMG/EEG Report _____Consultation Report

_____ALL MEDICAL AND PSYCHOLOGICAL RECORDS

_____Other:_____

Records for the period (dates) from_____ to _____

(continued on reverse)

I understand that I must check one or more of the following types of health information that I do not want released to the above-named Recipient. I understand that if I do not check any of the following three items, the health information released to the named Recipient may include any of the following:

_____ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse

_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment

_____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical, and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. This authorization shall remain valid unless revoked but **will expire in one year after signing**. I have a right to inspect a copy of the health information to be released, and if I do not sign this authorization, the organization named above will not release my health information. The above named person/organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/Legal Guardian/Personal Representative **Relationship to Patient**

_____

Witness

Re-disclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Bradley D. Powell, PhD and Psychological Consultants of the Brazos Valley, P.A. cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.